

How Health Coverage Works: Coverage Delivery, Risk Assessment, and Regulation

The following summarizes the document “How Private Health Coverage Works: A Primer 2008 Update” published by the Kaiser Family Foundation in April of 2008. Given the length of the Kaiser publication, this summary is designed to educate individuals on the basics of health coverage and provide a foundation for further discussion on options for reform of the small group market in Kansas. Explained in this document are how private health coverage is delivered, how risk is assessed, and how the private market is regulated by both the state and federal governments.

Delivery of coverage in the Private Market:

In this section we will review the two primary sources of private coverage available to the general population; employer sponsored coverage and insurance purchased through the individual market. In addition we will examine the different types of private health plans and health savings mechanisms.

Private Coverage in the Employer Market

There are two major kinds of health coverage in the employer market; fully insured health insurance and self-insured health insurance. Both small employers (2 – 50 employees) and large employers (51+ employees) can purchase either fully insured health coverage or can self-insure their health coverage. Practically, though, self-insurance is effectively limited to large employers that have enough members to spread the risk of providing self-insured health coverage. Under self-insurance, the employer assumes the risk of its employees’ health care by paying for the claims themselves rather than paying a premium. Benefits/claims administration is typically done by a third party (either an administrator or insurance carrier) hired by the employer. The third party administrator/carrier is typically paid an administrative fee for their service.

The most commonly purchased type of fully insured health insurance coverage by employers uses a preferred provider organization (PPO). PPOs are typically comprised of physician or other health care provider groups that provide discounted rates for health care services performed within their network. It is common for health care provider groups that comprise the PPO to contract with insurers to act as the network for the PPO in a particular area. The employee pays less for services utilized through the PPO when compared to services outside the PPO, known as “out-of-network” services. Another popular type of health insurance coverage purchased in the group market is through a health maintenance organization (HMO). HMOs are generally the most tightly managed fully insured product and are usually characterized by little or no out-of-network coverage. Typically defined by state law, HMOs act as both an insurer and health care provider by both spreading risk across enrollment and by directly arranging for or providing necessary health care for their enrollees.

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Private Coverage in the Individual Market

For those who are unemployed, self-employed, or who are employed by a firm that does not offer coverage, the individual market is the other primary option for private coverage. In terms of benefits, coverage purchased in the individual market is usually comparable to employer coverage. The cost in the individual market can be more or less that of the employer market depending upon your health status, due to medical underwriting performed at an individual level.

Affordability in Both Markets

Recent changes in federal law have tried to address the affordability of health coverage. These changes created new types of savings arrangements for health care. The most common of these are health savings accounts (HSA)s and health reimbursement accounts (HRA)s, which are tax-exempt accounts that can be used to pay for current or future qualified medical expenses. The limits for tax-exempt contributions into an HSA in 2008 are \$2,900 for self-only coverage and \$5,800 for family coverage. In order to participate in an HSA arrangement the enrollee must be enrolled in a HDHP (high deductible health plan), which is defined by a plan having a minimum deductible of \$1,100 (self-only) and \$2,200 (family) and a maximum out-of-pocket limit of \$5,600 (self-only) and \$11,200 (family). HRAs are established through employer sponsored coverage and funded solely by employer contributions into the account. The amount contributed is deducted from the employee's gross income. HRAs can be paired with HDHPs, however this is not required.

Risk Assessment and its role in Health Insurance Coverage:

Risk assessment determines how a person's potential risk affects premium costs and how potential risk is determined and managed.

From a conceptual perspective, risk pooling is done to make costs for a group more predictable and manageable. In order for an insurer's risk pool arrangements to perform well over time there needs to be consistency in the health risk of its enrollees. Insurers want to avoid attracting a disproportionate share of people in poor health into their risk pools; this is known as adverse selection. This can lead to the average costs per enrollee in the pool to rise. This increase in costs, when spread across all participants, makes the pool less desirable to people who are healthier, which can cause healthy individuals to leave. This causes premiums to rise dramatically, to more closely reflect the risk of those left in the pool, which could potentially result in a continued loss of good risk.

Insurers generally separate risk pools to insulate risk exposure across different lines of business such as small employer, large employer, or the individual market.

To maintain consistent risk within their pools, insurers utilize underwriting. The ability and type of underwriting varies by market; individual is the most heavily underwritten, small employers are subject to significant underwriting whereas large employer are subject to

substantially less underwriting. This process determines whether or not to accept an applicant for coverage, and if so, how much to charge them. For example, in the individual market, if the applicant is in poor health they may be turned down, or offered a “substandard rate”, meaning a higher than average rate or excluding benefits for certain health conditions or body parts, which is called an “exclusionary rider”. There are options in most states for those individuals turned down or offered a substandard rate, known as High Risk Pools. High Risk Pools are one tool that States use to insulate insurers’ risk pools from higher cost enrollees and adverse selection. In addition to underwriting, insurers maintain the attractiveness of a certain pool to certain segments of the population by varying premiums based on factors associated with health care costs such as age, gender, health status, occupation, and geographic location.

The risk of adverse selection grows as the group size gets smaller. When an insurer examines a group with a size of 2-5 employees, there are fewer individuals to spread the risk over. It is for this reason in most states insurance products sold in the small group market can be medically underwritten, meaning the insurer can examine the medical history of each employee in order to determine a group premium.

Policies written for large employers effectively avoid adverse selection because it is likely the members did not join the group primarily to get health insurance. When pricing large groups, underwriting practices are not directed at individual medical history, but rather group characteristics such as claims history, industry, geographic location, as well as age and gender distributions.

The Regulatory Environment of Health Insurance:

Private health coverage is regulated at both the state and federal levels. At the federal level, the Employee Retirement Income Security Act of 1974 (ERISA) regulates private health insurance coverage. ERISA, while most often cited as protection for employers against state regulation, was actually originally designed as a compromise to protect both employees and employers. To protect employees, ERISA set forth reporting, disclosure, and fiduciary duty requirements to enhance accountability and reduce the potential for fund abuse and mismanagement by benefit plan administrators. From an employer perspective, ERISA provides a uniform set of regulation surrounding employee benefit plans, easing administrative burdens, and consequently costs.

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, motivated by concern that people faced lapses in coverage when they change or lose their jobs, also has had a significant regulatory impact on private health insurance. In addition to addressing lapses in coverage, HIPAA also sets standards for the exclusion of benefits for preexisting conditions.

Regulation at the state level can build on these and other federal regulations already in place, however due to preemption of federal law they generally regulate the insurance business. Because the vast majority of Americans with health insurance coverage receive it

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through employee benefit plans understanding the interaction between federal and state laws is essential to understanding how coverage is regulated.

Federal Regulation:

Law/Regulation	Description
ERISA (Employee Retirement Income Security Act)	<ul style="list-style-type: none">○ To protect employees, ERISA set forth reporting, disclosure, and fiduciary duty requirements to enhance accountability and reduce the potential for fund abuse and mismanagement by benefit plan administrators.<ul style="list-style-type: none">▪ Disclosure – A summary plan design (SPD) must be given to participants and beneficiaries, clearly defining benefits covered▪ Reporting Requirements – Requires administrators of a plan to file an operations report to the IRS (self-funded groups larger than 100 and fully insured groups are exempt)▪ Fiduciary Requirements – Requires fiduciaries to carry out their responsibilities “solely in the interest of (plan) participants and beneficiaries and for the exclusive purpose of providing benefits...and defraying reasonable expenses of administering the plan”○ To protect employers, ERISA provides a uniform set of regulation surrounding employee benefit plans, easing administrative burdens, and consequently costs.<ul style="list-style-type: none">▪ The main concern of ERISA is regulating “benefit plans,” which are defined as any plan, fund, or program which is established or maintained by an employer or by an employee organization, or by both, for the purpose of providing for its participants through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.▪ The Supreme Court has emphasized that ERISA is concerned with “benefit plans,” rather than simply “benefits,” because only plans involve administrative activity potentially subject to employer abuse.○ Continuation of Coverage (COBRA) – Amended by the Consolidated Omnibus Budget Reconciliation Act of 1985, requires plan sponsors that employ 20 or more employees to offer continuation of coverage to qualified beneficiaries (including dependents) who lose health coverage under an employee benefit plan for certain specified reasons (e.g., death of an employee, termination of employment, divorce, or legal separation).
HIPAA (Health Insurance Portability and Accountability Act)	<ul style="list-style-type: none">○ Preexisting condition exclusions and portability – HIPAA requires state licensed insurers issuing group coverage to limit preexisting condition exclusion periods to no more than 12 months (18 months for late enrollees unless they enroll under certain circumstances). For individuals moving from one group plan to another any pre-existing condition exclusionary period must be reduced by the

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	<p>number of days the newly enrolling person was covered by public or private coverage. The time lapse between coverage must be shorter than 63 days. The preexisting condition exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before the enrollment date.</p> <ul style="list-style-type: none"> ○ Access to coverage – There is a guarantee of coverage for small group employees 2-50 as defined under HIPAA. To be eligible the person must not be eligible for other public or private group health coverage, must have had public or group coverage for 18 continuous months, applied for new coverage within 63 days of leaving group coverage, and have exhausted any state or federal continuation rights under their group policy. However, states have considerable flexibility in determining the mechanism for making coverage available to eligible people. For example, in most states, eligible people are guaranteed access to coverage in the state's high-risk pool; private insurers are not required to sell coverage to them. HIPAA generally does not regulate the premiums that people can be charged for the coverage that is offered under HIPAA. ○ Renewability – Coverage in group arrangements can be renewed at the end of a period of coverage. Coverage can only be terminated due to cases of non-payment of premium and fraud. ○ Nondiscrimination – This prohibits state licensed insurers from considering the health status of a member of the group in determining the member's eligibility for coverage, premium contribution, or cost-sharing requirements.
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State Law:

Issue	Description
Access to Coverage and Required Benefits	<ul style="list-style-type: none"> ○ Access to coverage standards refer to states requiring state-licensed health insuring organizations to provide coverage to those who apply with limitations on the rates that can be charged (how much they can vary by age and health status). ○ A similar concept is renewability, which addresses the extent to which a purchaser has the right to renew a policy for another year without being reevaluated for coverage. ○ Some states also require insurers to provide certain benefits to their enrollees, such as mental health services, substance abuse treatment, and preventive care. ○ There are also regulations in place to address the ability of insurers to restrict coverage, such as excluding pre-existing conditions. Limits on these exclusions will generally be applied when someone is switching from one policy to another.
Premium Regulation	<ul style="list-style-type: none"> ○ Premiums can be regulated by setting standards for minimum loss ratios, rate bands, and by adopting community rating. ○ Loss ratio standards dictate what % of each premium dollar must be

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	<p>spent on providing medical benefits, and what can be used for administrative costs and profit.</p> <ul style="list-style-type: none">○ Rate banding controls how much rates can vary due to age, gender, health status, or claims experience.○ Community rating is when all policyholders are charged the same premium, and the only variation can be due to demographic factors such as age, gender, and location.
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